| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Parma Care Center | 5553 Broadview Rd<br>Parma, OH 44134 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation, review of physician orders, review of the bowel movement (BM) log, review of the hospital discharge instructions, review of the medical records, review of the facility policy Bowel Management and Treatment and interviews with the Director of Nursing, Regional Nurse #625 and Certified Nurse Practitioner (CNP) #626 the facility failed to provide appropriate care and treatment of constipation for one resident (Resident #53) who had an established diagnoses of constipation and physician orders to prevent exacerbation of the constipation. This resulted in Immediate Jeopardy on 03/02/22 when Resident #53, who had not had a bowel movement for four days, was not assessed for constipation and no treatment was provided by the facility. On 03/05/22 Licensed Practical Nurse (LPN) #503 identified the lack of bowel movement, administered milk of magnesia (MOM), charted the MOM was ineffective but implemented no further bowel interventions. Resident #53 continued to have no bowel movement, except for a small amount on 03/06/22. On 03/09/22 Resident #53 had a medium bowel movement followed by no bowel movement on 03/10/22, 03/11/22, 03/12/22, 03/13/22 and 03/14/22. No action was taken by the facility to assess the lack of BMs or intervene on the lack of BMs during this time frame. Resident #53 was sent out to the hospital on 03/20/22 with a firm distended abdomen and sluggish bowel sounds. A fecal impaction was diagnosed at the hospital. This affected one (Resident #53) of four residents reviewed for abuse and neglect. The facility census was 73.<br><br>On 08/03/22 at 11:46 A.M., the Administrator, DON, Regional Nurse #625, and Corporate Director of Clinical Services (CDOCS) #621 were notified Immediate Jeopardy began on 03/02/22 when Resident #53 had three consecutive days, 02/27/22, 02/28/22 and 03/01/22 with no bowel movement and was not assessed for constipation and no effective treatment was provided by the facility.<br><br>The Immediate Jeopardy was removed on 08/04/22 when the facility implemented the following corrective actions:<br><br>Resident #53 was reassessed on 08/03/22 at 1:00 P.M. by RN #804 to find no changes in baseline.<br><br>All 80 residents were assessed on 08/03/22 between 12:30 P.M. and 4:00 P.M. by RN #804, RN #803 and RN #805 for bowel issues. Changes in condition were being addressed timely and appropriate care and services were being provided. There were no negative outcomes to any resident because of the findings.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility bowel and bladder policy and procedure were reviewed on 08/03/22 to ensure licensed staff can identify and manage bowel treatment. This treatment will be timely so appropriate care and services can be provided so no residents experience a bowel condition that is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. The policy and procedure are as follows:<br><br>A bowel condition is a clinical change in the resident's bowel pattern that would result in the lack of a bowel movement for a period of 72 hours. The licensed nurse will initiate a bowel toileting review for all residents upon admission, quarterly, and with significant change. The appropriate level of care and treatment will be delivered as required to best manage a resident's bowel condition. This will include residents who have not had a bowel movement for three consecutive days will have the following protocol initiated, unless a resident has individual orders specific to bowel management, or where the orders below would be contraindicated for the resident.<br><br>The initial nurse receiving the alert, and identifying the lack of BM for three days, will begin the following bowel protocol for the residents on the list: assess bowel sounds, administer 30cc of MOM. If the resident refuses the MOM, the nurse will notify the attending physician and document such on the MAR and in the nurse's notes. Document on the MAR and in the nurse's notes when the resident has a bowel movement and then the resident will be placed on the modified promotional bowel regimen as listed above.<br><br>The medication nurse on the next shift will check the list upon beginning her shift and the following will be performed: assess for bowel sounds and if the resident does not have a bowel movement within eight hours of the MOM, the licensed nurse will administer a suppository (type and amount to be determined by the physician or the Medical Director) to be given at HS per physician's order. If the resident refuses the suppository, the nurse will notify the attending physician and document such on the MAR and in the nurse's notes. Document on the MAR and in the nurse's notes when the resident has a bowel movement and then the resident will be placed on the promotional bowel regimen.<br><br>The medication nurse for the 3rd consecutive/next shift, will check the list at the start of her shift and the following will be performed: assess bowel sounds. If the resident does not have a bowel movement within eight hours of receiving the suppository, the nurse will administer an enema. If the resident refuses the enema, the nurse will notify the attending physician and document such on the MAR and in the nurse's notes. Document on the MAR and in the nurse's notes when the resident has a bowel movement and then place the resident on the promotional bowel regimen. If the resident does not have a bowel movement within one hour of receiving the enema, notify the attending physician for further instructions and document such in the MAR and in the nurses notes.<br><br>The Corporate Director of Clinical Services (CDOCS) #621 re- educated the Director of Nursing on 08/03/22 on ensuring staff provide appropriate bowel monitoring and treatment as per the facility Bladder and Bowel/Urinary Assessment policy and the facility Bowel Management and Treatment policy.<br><br>The Director of Nursing educated the licensed nursing staff ( 13 LPNs by phone, 2 LPNs in person, 3 RNs by phone and 7 RNs in person) on 08/03/22 and 08/04/22 on ensuring staff provide timely and appropriate bowel care. This education was completed by review of the facility Bladder and Bowel/Urinary Assessment policy and the facility Bowel Management and Treatment policy. Education of 100% of total licensed staff will be completed by 08/04/2022.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An audit tool was implemented for the Director of Nursing and/or designee (RN #805) to monitor for the compliance of providing timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. The audit will monitor for resident's bowel frequency and management. The DON or designee (RN #805) will conduct an audit on four residents on each unit, at random each week for four weeks, then bi-weekly for two weeks, and then monthly for one week.<br><br>All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review and prompt response and resolution. The Administrator and/or designee (DON) will monitor this area for ongoing compliance.<br><br>Although the Immediate Jeopardy was removed on 08/04/22, the deficiency remained at a Severity Level of 2 (No actual harm with the potential of more than minimal harm) as the facility was continuing to monitor for compliance with care and treatment when a resident experienced a change in condition.<br><br>Findings included:<br><br>Record review for Resident #53 revealed an admitted [DATE]. Diagnosis included Parkinson's disease, multiple sclerosis epilepsy, dementia, muscle weakness and constipation.<br><br>Record review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had severe cognitive impairment scoring five out of 15 points on the Brief Interview for Mental Status (BIMS). Resident #53 required extensive physical assistance of one-person for bed mobility, transfers, locomotion on the unit, assistance on and off the toilet and for personal hygiene.Resident #53 had an indwelling catheter and was always continent of bowel.<br><br>Record review of the care plan dated 08/20/18 revealed Resident #53 had potential for constipation related to decreased mobility and a history of constipation. Resident #53's care plan goal was the resident will pass soft, formed stool at a minimum of every three days. The intervention included to follow the facility bowel protocol for bowel management.<br><br>Record review of the physician orders for Resident #53 for the month of March 2022 revealed on 02/16/21 Resident #53 received the following orders:<br><br>1. Milk of magnesia 400 milligrams (mg) per five milliliters (ml), give 30 ml by mouth as needed for constipation once daily per bowel protocol administer once daily if no bm (bowel movement) in three consecutive days.<br><br>2. Bisacodyl laxative suppository 10 mg insert one rectally as needed for constipation once daily at night if no bm eight hours after MOM.<br><br>3. Enema mineral oil insert 118 ml rectally as needed for constipation once daily if no bm eight hours after receiving suppository. If no bm within one hour after receiving enema notify the physician.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review for Resident #53 of the facility document titled BM log and the MAR for 02/27/22 through 03/20/22 revealed Resident #53 had no BM for three days (02/27/22, 02/28/22 and 03/01/22), and on the fourth day 03/02/22 Resident #53 should have received the physician ordered bowel protocol but did not. Resident #53 continued to have no bowel movement on 03/03/22 and 03/04/22. On 03/05/22 the nurse gave Resident #53 MOM and charted the MOM was ineffective on the MAR. No further bowel interventions or abdominal assessment was evidenced in the chart as completed by the nurse. Resident #53 continued to have no bowel movement from 03/2/22 to 03/9/22 when he had a medium bowel movement on 03/09/22. During the period 03/02/09 to 03/09/22, no bowel assessment was documented, and the physician had not been notified. Resident #53 again had no bowel movement on 03/10/22, 03/11/22, 03/12/22, 03/13/22 or 03/14/22. No assessment was completed, the bowel protocol again was not initiated on 03/13/22 or 03/14/22. Resident #53 had a large bowel movement documented 03/15/22. Resident had none on 03/16/22, had two mediums 03/17/22, one medium on 03/18/22 and one medium on 03/19/22. Resident #53 was sent to the hospital on 03/20/22 due to sluggish bowel sounds and a firm, distended abdomen and diagnosed with a bowel impaction.<br><br>Record review of the Nursing Progress Note dated 03/20/22 at 10:48 A.M. completed by Licensed Practical Nurse (LPN) #503 revealed Resident #53's super pubic (s/p) catheter was leaking large amounts of urine. The catheter was changed. Upon insertion it was noted Resident #53's abdomen was distended and firm with sluggish bowel sounds. The record review included the physician was notified and the nurse received a new order to send Resident #53 to Hospital #624.<br><br>Record review of the Nursing Progress Note dated 03/20/22 at 9:55 P.M. completed by LPN #540 revealed Resident #53 was returning from Hospital #624 with the hospital reporting he was impacted, and they gave him a laxative and disimpacted him. Resident #53 also had a urinary tract infection (UTI) and was given a dose of Levaquin antibiotic. He would return to the facility with orders for the antibiotic.<br><br>Record review of Hospital #624 discharge instructions for Resident #53 dated 03/20/22 under additional notes and instructions completed by Emergency Physician #905 revealed Resident #53 had been treated with a fecal disimpaction done in the emergency department and his urine appeared infected. The hospital discharge instructions included instructions for the prescribed antibiotic and instructions for constipation.<br><br>Interview on 08/02/22 at 8:09 A.M. with the DON confirmed Resident #53's BM log was where the bowel movements were documented by staff for Resident #53. The DON verified Resident #53's medical record did not contain evidence of the Bowel Management and Treatment protocol being implemented or evidence Resident #53's physician orders for the bowel protocol had been followed for the period 03/01/22 through 03/19/22.<br><br>Interview and record review on 08/02/22 at 10:15 A.M. with the DON and Regional Nurse #625 revealed they located a progress note for Resident #53 completed by Certified Nurse Practitioner (CNP) #626 dated 03/18/22. Review of the document provided by the DON and Regional Nurse #625 revealed it was titled Medical Rounding Note, dated 03/18/22 and authored by CNP #626. The note indicated it was Resident #53's monthly progress note. Resident #53 was found sitting up in a wheelchair in the dining room, he was mildly confused with impaired short-term memory and denied pain, nausea, vomiting, constipation, diarrhea, or cough. Resident #53's bowel sounds were circled as both positive and negative and the abdomen was noted as soft and round.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 08/02/22 at 12:37 P.M. with CNP #626 revealed Resident #53 was not a good historian so she would talk to the nursing staff to obtain information. CNP #626 revealed on her visit, she did look at Resident #53's abdomen revealing he always had a pot belly. Resident #53 had a super pubic catheter and had a history of constipation. CNP #626 revealed she did not have access to the resident's stool (BM) log in the computer so she would ask the nursing staff regarding concerns. CNP #626 revealed on this occasion (03/18/22) the nursing staff told her Resident #53 had no constipation concerns.<br><br>Interview and observation on 08/03/22 at 11:09 A.M. with Resident #53 revealed Resident #53 was sitting in the television lounge watching television. Resident #53 was alert but could not verbalize his location, date, or the time. When asked if he ever had constipation, resident stated, I am not sure.<br><br>Record review of the facility policy titled, Bowel Management and Treatment, dated October 2017, revealed residents who have not had a bowel movement (BM) for three consecutive days will have the following protocol initiated, unless resident has individual orders specific to bowel management or where the orders would be contraindicated for the resident:<br><br>1. The Initial nurse receiving the alert and identifying the lack of bm for three days, will begin the following bowel protocol: assess bowel sounds, administer 30 milliliters (ml) milk of magnesium (MOM). If the resident refuses the MOM the nurse will notify the physician and document such on the MAR and in the nurses note. The nurse will document on the Medication Administration Record (MAR) and in the nurses note when the resident has a bowel movement and then the resident will be placed on a modified promotional bowel regimen as is listed above. (Review medications, obtain physician orders, daily administration of natural laxatives or prune fiber mixture, increase fluid intake, assess bowel sounds each shift and document, the licensed nurse will document on the MAR or Treatment Administration Record (TAR) when the resident has had a BM.<br><br>2. The medication nurse on the next shift will check the list on beginning of her shift and the following will be performed: assess for bowel sounds. If the resident has not had a bowel movement within eight hours of MOM, the licensed nurse will administer a suppository given at bedtime (HS) per the physician's order. If the resident refuses the suppository the nurse will notify the physician and document such on the MAR and in the nurses note. The nurse will document on the MAR and in the nurses note when the resident has a bowel movement and then the resident will be placed on a modified promotional bowel regimen as is listed above.<br><br>3. The medication nurse for the consecutive/next shift will check the list at the start of the shift and the following will be performed: assess for bowel sounds. If the resident has not had a bowel movement within eight hours of receiving the suppository, the licensed nurse will administer an enema. If the resident refuses the enema the nurse will notify the physician and document such on the MAR and in the nurses note. The nurse will document on the MAR and in the nurses note when the resident has a bowel movement and then the resident will be placed on a modified promotional bowel regimen as is listed above. If the resident does not have a bowel movement within one hour of receiving the enema, notify the physician for further instruction and document such on the MAR and in the nurses note. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on observation, interview, record review and review of facility policy, the facility failed to ensure incontinence care was provided timely for two residents (Residents #27 and #226) and failed to ensure one resident (Resident #226) was shaved. This affected two residents (Residents #27 and #226) out of three residents reviewed for care for dependent residents. The facility census was 73.<br><br>Findings include:<br><br>1. Review of Resident #226's medical record revealed an admitted [DATE], a re-entry date of 07/21/22, and diagnoses included Wernicke's encephalopathy, schizophrenia, and dementia.<br><br>Review of Resident #226's Admission Minimum Data Set (MDS) 3.0 assessment revealed Resident #226 had severe cognitive impairment. Resident #226 required extensive assistance of one staff member for bed mobility, toilet use and personal hygiene. Resident #226 was always incontinent of urine.<br><br>Observation on 07/26/22 at 11:39 A.M. of Resident #226 revealed him sitting in his wheelchair near the nurses station. Resident #226 had several days growth of facial hair and was dressed in a hospital gown and socks.<br><br>Observation on 07/27/22 at 8:30 A.M. of Resident #226 sitting in the hall in his wheelchair wearing a hospital gown and socks, and still had not been shaved showing several days growth of facial hair.<br><br>Review of Resident #226's care plan dated 07/28/22 included Resident #226 had an Activity of Daily Living (ADL) self-care performance deficit related to diagnoses. Resident #226 would achieve maximum ADL function through next the review. Interventions included Resident #226 required extensive assist of one staff to maximize independence. Resident #226 required extensive to total assist of one staff for toileting. Resident #226 had potential impairment to skin integrity related to fragile skin, including impaired mobility, incontinence of bowel and bladder. Resident #226 would maintain or develop clean and intact skin by the review date. Interventions included to keep skin clean and dry, and keep body parts from excessive moisture.<br><br>Review of Resident #226's progress notes on 7/29/2022 at 10:14 P.M. written by Licensed Practical Nurse (LPN) #530 included Resident #226's sister had the resident standing behind his wheelchair with his pants down and door open. Resident #226's sister stated her brother never looked like this when she took care of him. Resident #226's sister proceeded to take pictures of Resident #226 on her phone. When asked why she had his pants down Resident #226's sister said his scrotum was never red like this when she took care of him. Resident #226's sister lifted the residents scrotum and started to take pictures with her phone sending them to someone as evidence by Resident #226's sister asking a person on the phone do you see how red he is? Resident #226's sister also continued to take pictures of his buttocks. The Certified Nurse Practitioner (CNP) was notified of Resident #226's excoriation and a treatment for excoriation was started to his scrotum and upper thighs per CNP orders.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #226's physician orders dated 07/29/22 revealed dermaseptin (skin barrier ointment) to by applied to his scrotum and perineal area every shift after incontinence care to promote skin integrity.<br><br>Review of Resident #226's shower sheets dated 07/22/22, 07/26/22, and 08/02/22 did not reveal documentation Resident #226 had his face shaved. Review of Resident #226's shower sheet dated 07/29/22 stated no to the question was face shaved.<br><br>Observation on 08/03/22 at 9:34 A.M. of State tested Nursing Assistant (STNA) #547 providing incontinence care for Resident #226 revealed his incontinence brief was wet, but not saturated. STNA #547 stated Resident #226's incontinence brief was dry when she checked it at 7:00 A.M. STNA #547 stated Resident #226 was sleeping at 7:00 A.M. and she did not notice if his gown and draw sheets were wet. Observation did not reveal redness or skin breakdown, but the bottom part of Resident #226's gown was wet and two reusable cloth draw sheets were wet underneath him. STNA #547 stated the night shift aide must have changed his brief but not his gown or the cloth draw sheets.<br><br>Observation on 08/03/22 at 2:45 P.M. with Registered Nurse (RN) #602 and STNA #547 revealed Resident #226 had beard stubble his on face.<br><br>Interview on 08/03/22 at 3:46 P.M. with STNA #547 confirmed Resident #226 had stubble on his face. STNA #547 stated she did not have time to shave him this morning, and was planning on it this afternoon but her assignment changed and she was moved to a different nursing unit and was unable to shave Resident #226.<br><br>Review of the facility policy titled Personal Care/Bathing, revised 10/2017 included shaving was offered to resident daily during the routine bathing process.<br><br>2. Review of Resident #27's medical record revealed an admitted [DATE] and diagnoses included dementia with behavioral disturbance and weakness.<br><br>Review of Resident #27's Admission MDS 3.0 assessment dated , 05/04/22 revealed Resident #27 had moderate cognitive impairment and required extensive assistance of one staff member for bed mobility and toilet use. Resident #27 was always incontinent of urine and frequently incontinent of bowel.<br><br>Review of Resident #27's care plan dated, 07/29/22 included Resident #27 had bowel and bladder incontinence related to activity intolerance, confusion,dementia, impaired mobility, inability to communicate needs, physical limitations and pain. Resident #27 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to provide incontinence care with care rounds every shift.<br><br>Observation on 08/03/22 at 10:35 A.M. with STNA #547 of incontinence care for Resident #27 revealed her incontinence brief was very wet. STNA #547 stated she did not check her before now because she was busy getting other residents up and serving breakfast. Observation of a dark red area across Resident #27's coccyx approximately 4 inches long with a purple area in the center of the red area was noted. The red area extended across the coccyx and bilateral buttocks. STNA #547 stated the residents on the nursing unit required a lot of assistance from the staff and it was hard to get to the residents in a timely manner. STNA #547 stated she did not care for Resident #27 on 08/02/22 and did not know when she developed the red area on her coccyx.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 08/03/22 at 10:55 A.M. with LPN #521 revealed on 07/31/22 she was assigned to the nursing unit Resident #27 resided on and Resident #27 did not have a red area on her coccyx. LPN #521 stated Resident #27 had been lying in her bed a lot because she had COVID-19 and just came off precautions a couple days ago. LPN #521 confirmed the red area extended across the coccyx and bilateral buttocks and had a purple center. Observation of LPN #521 revealed she pushed on the red and purple areas, the red area blanched within three seconds and the purple area sluggishly blanched.<br><br>An interview on 08/03/22 at 11:02 A.M. with Registered Nurse/Wound Nurse (RN/WN) #803 confirmed the red and purple areas across Resident #27's coccyx and buttocks. Resident #27 stated the area did not hurt.<br><br>Review of Resident #27's progress notes dated 08/3/2022 at 11:14 A.M. included Resident #27 had a reddened area to coccyx. Intact linear blanchable reddened area noted across coccyx area. Notified CWOCN (Certified Wound Ostomy Incontinence Nurse), would assess during next rounds day. See new orders for Triad cream every shift and no brief in bed to promote skin integrity. Resident denied pain.<br><br>Review of Resident #27's medical record including progress notes from 07/27/22 through 08/03/22 did not reveal documentation Resident #27 had a red and purple area across her coccyx and buttocks.<br><br>This deficiency substantiates complaint number OH00134604. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation, interview, record review, and review of the Employee Handbook, the facility failed to ensure activities were provided in a dignified and professional manner for 11 residents (Resident #22, #45, #19, #64, #21, #67, #04, #68, #03, #60, and #224) of 31 residents who resided in the Memory Care Unit. The facility census was 73.<br><br>Findings include:<br><br>Observation while in the Memory Care Unit on 07/25/22 at 3:26 P.M. revealed 11 residents, Resident #22, #45, #19, #64, #21, #67, #04, #68, #03, #60, and #224, were sitting at a table in the lounge area of the Memory Care Unit. The lounge area was located directly across from the nurses station. Activities Director #515 was sitting at the head of the table in the lounge area with the 11 residents. Licensed Practical Nurse (LPN) #521 was working at the nurses station. LPN #521 revealed residents were in a group activity. Observation revealed during the activity, Activities Director #515 asked multiple questions including if anyone knew what a blunt was. The Residents appeared confused while looking at Activities Director #515, some grimacing, some smiling, and some just looking at her with no expression. Activities Director #515 then explained different definitions of a blunt including it was marijuana, while making hand gestures of smoking a blunt while laughing. Activities Director #515 explained to the residents she smoked blunts back in the day and you'd know if it was a good blunt if you got the munchies. If it was a bad blunt you did not get the munchies (while continuing to make hand gestures of smoking while laughing). Activities Director #515 went on to ask the residents if any of them knew what a [NAME] was and gave a description of a [NAME] to the Residents.<br><br>Interview on 07/26/22 at 3:45 P.M. with Activities Director #515 revealed when she was sitting in a group with the 11 residents on 07/25/22 she was doing a Fun in Words activity titled 60's slang. Activities Director #515 explained the resident's were a black culture and blunt and [NAME] were what they knew from their generation being in a black culture.<br><br>Interview on 07/27/22 at 7:40 A.M. with the DON revealed discussing smoking blunts using hand gestures, and discussing hookers would not be an appropriate activity.<br><br>Interview on 07/27/22 at 7:55 A.M. with LPN #521 verified she was at the nurses station on 07/25/22 during afternoon activity and verified the activity would not be appropriate for all of the residents who were at that activity.<br><br>Record review of the Employee Handbook, revised September 2012, revealed a section listed under employee conduct explaining kindness, patience and respect towards residents, visitors and one another were mandatory, and friendly and professional atmosphere should prevail at all times. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation of Resident #04, review of the medical records for Resident #04, Review of the current, online Medscape application titled Medscape Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus, review of the facility policy titled Status Change in Resident Condition Notification, dated October 2017, and interviews with the Director of Nursing (DON), Physician #900 and Licensed Practical Nurse (LPN) #574, the facility failed to provide timely care and services for the monitoring and treatment of Resident #04s' hyperglycemia with a blood glucose level greater than 500 milligrams (mg) per deciliter (dL) for 12 hours. This resulted in Immediate Jeopardy on 03/26/22 at approximately 10:51 A.M. when Resident #04, who was not previously diagnosed with diabetes, was noted to have excessive urination with incontinence (loss of urine control), high ketones (chemical derived from fat in the body when the body is unable to use glucose for energy and is an indicator of a life threatening condition known as diabetic ketoacidosis) with a blood glucose of 531 mg/dl and did not receive medical treatment for the blood sugar that continued to be greater than 500 mg/dl until after arriving in the emergency room (ER), greater than 12 hours after Resident #04 was first found to have symptoms of hyperglycemia. This affected one, Resident #04, of three residents reviewed for hospitalization . The facility census was 73.<br><br>On 07/28/22 at 12:45 P.M., the Administrator, DON, and Corporate Director of Clinical Services (CDOCS) #621 were notified Immediate Jeopardy began on 03/26/22 at 10:51 A.M. when Resident #04 did not receive care and treatment for a blood sugar greater than 500 mg/dl for 12 hours.<br><br>The Immediate Jeopardy was removed on 07/29/22 when the facility implemented the following corrective actions:<br><br>o Resident #04 was assessed on 07/29/22 by LPN #800 and there were no changes found from Resident #04's baseline.<br><br>o All 80 residents were assessed for change of condition beginning 07/28/22 at 6:00 P.M. through 07/29/22 at 11:29 A.M. by LPN #800, #801, #802, RN #803 and #804. No changes in baseline were identified since the findings of the immediate Jeopardy citation.<br><br>o The facility updated the Resident Change in Condition policy and procedure on 07/28/22 to ensure licensed staff can identify and direct timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes.<br><br>o The Corporate Director of Clinical Services (CDCS) #621 educated the Director of Nursing (DON) on 07/28/22 on ensuring staff provide timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. The contents of the education consisted of the following:<br><br>- The facility Resident Change in Condition policy and procedure<br><br>- Identifying changes in physical, psychosocial and/or mental changes<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Ensuring staff provide timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes.<br><br>- Interventions if a change in condition is identified as stated in policy<br><br>- Definitions of acute and significant change of condition<br><br>- Monitoring of elevated blood sugar levels while awaiting physician return call<br><br>- Process of notifying condition and interventions to take if unable to contact physician including confirming transport and wait time.<br><br>- Utilizing the audit tool to validate resident status and appropriateness of care match and contain all pertinent information and actions needed to provide and meet a residents medical, nursing, and mental and psychosocial needs if a change of condition is identified.<br><br>o The DON on 07/29/22 educated nine of nine RNs and 11 of 11 LPNs in person or by telephone on ensuring staff provide timely and appropriate care and services when residents experience a change in condition that has or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. Education of 100% of total licensed nursing staff would be completed on 7/29/2022.<br><br>o An audit tool was implemented for the DON and designee (RN #805) to monitor for the compliance of providing timely and appropriate care and services when residents experience a change in condition (physical, non-physical and/or mental status change) that has or is likely to cause serious life-threatening harm or injuries and/or adverse negative health outcomes. The DON and/or RN # 805 will conduct an audit on four residents on each unit, at random weekly for four weeks, then bi-weekly for two weeks, and then monthly for one week.<br><br>o All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review and prompt response and resolution.<br><br>o The Administrator and/or designee (DON) will monitor this area for ongoing compliance.<br><br>Although the Immediate Jeopardy was removed on 07/29/22, the deficiency remained at a Severity Level of 2 (No actual harm with the potential of more than minimal harm) as the facility was continuing to monitor for compliance with care and treatment when a resident experienced a change in condition.<br><br>Findings included:<br><br>Review of Resident #04's medical record revealed he was admitted to the facility on [DATE] with diagnosis including severe protein calorie malnutrition and adult failure to thrive. Additional diagnosis of unspecified dementia without behavioral disturbances was added on 04/22/21.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the quarterly Minimum Data Set 3.0 (MDS) assessment for Resident #04 dated 01/07/22 revealed Resident #04 had severe cognitive impairment scoring six out of 15 points on the Brief Interview for Mental Status (BIMS). Resident #04 required supervision and/or assistance with all activities of daily living. Resident #04 was always continent of urine. Resident #04 had no diagnosis of diabetes mellitus.<br><br>Review of the nursing note for Resident #04 dated 03/26/22 at 10:51 A.M. completed by Licensed Practical Nurse (LPN) #574 revealed Resident #04 was noted having excessive urination with episodes of incontinence. His urine was checked with a chem-strip to rule out a urinary tract infection and was noted with a large amount of ketones (high ketone levels may indicate diabetic ketoacidosis (DKA) a complication of diabetes that can lead to coma or even death). Documentation included LPN #574 assessed Resident #04's blood sugar with a result of 568 mg/dL. LPN #574 rechecked Resident #04's blood sugar with another glucometer and was noted 531 mg/dL. Primary Physician (PP) #901 was called, and LPN #574 was awaiting a call back.<br><br>Record review of the Nurses Note for Resident #04 dated 03/26/22 at 1:26 P.M. completed by LPN #574 revealed PP#901 was called again and LPN #574 continued to await a call back.<br><br>Record review of the nurses note for Resident #04 dated 03/26/22 at 3:57 P.M. completed by LPN #574 revealed Physician #900, who was the on-call physician, called back for PP#901 and gave a new order to send Resident #04 to the emergency room of Hospital #624 for an evaluation.<br><br>Record review of the nurses note for Resident #04 dated 03/26/22 at 9:32 P.M. completed by LPN #540 revealed LPN #540 spoke with community transport service (CTS) #806 and CTS #806 stated pick up would be within 15-20 minutes.<br><br>Record review of the nurses note for Resident #04 dated O3/26/22 at 9:47 P.M. completed by LPN #540 revealed Resident #04 continued to be incontinent of bladder.<br><br>Record review of the nurses note for Resident #04 dated O3/26/22 at 9:54 P.M. completed by LPN #540 revealed Resident #04's blood sugar was 521 mg/dL and was still awaiting transport to the emergency room by CTS #806.<br><br>Record review of the nurses note for Resident #04 dated O3/26/22 at 10:50 P.M. completed by LPN #540 revealed CTS #806 arrived to take Resident #04 to the hospital.<br><br>Record review of the meal intake records for 03/26/22 revealed the facility served breakfast and lunch to Resident #04 of which he ate 50 percent of both meals. There was no record to reflect if he had been served dinner on 03/26/22 and no additional blood glucose monitoring had been done before or after the meal service.<br><br>Record review of the nurses note for Resident #04 dated O3/27/22 at 6:30 A.M. completed by LPN #540 revealed Resident #04 was admitted to Hospital #624 with a diagnosis of diabetic ketoacidosis (DKA - a complication of diabetes that can lead to coma or even death).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation and interview were conducted on 07/27/22 of Resident #04 who was found watching television in room. The resident presented as alert with confusion, and unable to carry on a factual, reciprocal conversation with the surveyor. When asked simple questions he provided unrelated, off topic answers illustrative of his cognitive impairment.<br><br>Record review and interview on 07/27/22 at 3:47 P.M. of Resident #04's medical record for 03/26/22 with the DON confirmed Resident #04 should have been sent to the hospital for emergency medical services on 03/26/22 at 10:41 A.M. via 911 when he was noted to have excessive urination with episodes of incontinence, high ketones and a blood glucose of 531 mg/dlL The DON verified Resident #04 should have been sent to the hospital emergency room (ER) via 911 as a nursing measure responding to an emergent situation requiring immediate medical attention. The DON verified a nurse should send a resident to the ER via 911 emergency when the nurse was unable to contact the physician, then the nurse would update the physician when the physician returned the call. The DON confirmed 03/26/22 was a Saturday and she was not made aware at that time of this situation by any nurse.<br><br>Review of the hospital record dated 03/27/22 completed by Hospital Physician #903 revealed Resident #04 had no history of diagnosed diabetes mellitus, was not on insulin or oral hypoglycemics (medication taken by mouth to decrease blood glucose levels). Resident #04 had a history of hypertension, heroin use, and coronary disease. Resident #04 presented to the emergency department from the skilled nursing facility for elevated blood sugars and polyuria (excessive urination) for the last few days. In the emergency room the vital signs were stable, slightly tachypneic (rapid heart rate) and the data was significant for hyperglycemia and blood glucose above 500 mg/dL Resident #04 was ordered to receive intravenous fluids and insulin (medication used to decrease elevated blood glucose levels) in the emergency department. Physician #903's assessment of Resident #04 stated newly diagnosed with diabetes mellitus likely type two, with diabetic ketoacidosis and hypercalcemia (high calcium level). The plan was to start an intravenous (IV) insulin drip and adjust it as needed, give IV fluids, monitor kidney function panel, monitor anion gap and replace electrolytes as needed.<br><br>Interview on 07/28/22 at 8:30 A.M. with LPN #574 revealed when she first called PP #901, there was no answer. LPN #574 explained Resident #04 was not diabetic, he was just urinating a lot and incontinent. LPN #574 confirmed when she finally got ahold of the physician on call, Physician #900 (03/26/22 at 3:57 P.M.), Physician #900 stated to send Resident #04 to the emergency room . LPN #574 said Physician #900 did not say how to send Resident #04 to the ER, so she decided to send Resident #04 to the ER via CTS #806. LPN #574 stated, So we just monitored him, and he seemed fine.<br><br>Interview on 07/28/22 at 9:15 A.M. with Physician #900 revealed when she gave orders to send a resident to the emergency room , she expected them to be sent 911. If 911 could not come immediately, the least she would expect was a call back to let her know 911 could not come immediately. Physician #900 repeated her expectations where residents were to be sent 911 when orders were given to send a resident to ER. Physician #900 expressed sending a resident any other way, when she gave orders to send the resident to the ER, would have been unacceptable and at the least, she would have expected to be called back to let her know 911 would not be coming immediately.<br><br>Interview on 07/28/22 at 10:31 A.M. with Supervisor #807 at CTS #806 revealed CTS #806 was a private ambulance company. Supervisor #807 revealed 911 service stayed in the city and CTS #806 covered 13 counties. Supervisor #807 revealed if someone was at a nursing home and needed immediate service, the facility should call 911 because it was quicker because CTS #806 provided service all over Ohio for transports and it could take much longer before a resident was picked up.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the online, current Medscape application titled Medscape Report of the Expert Committee on the Diagnosis and Classification of diabetes mellitus indicates a blood sugar level less than 140 mg/dL is normal.<br><br>Record review of the facility policy titled, Status Change in Resident Condition - Notification dated October 2017, revealed the facility will promptly notify the resident, his/her attending physician and responsible party of changes in the residents' condition and or status. The licensed nurse will notify the residents attending physician for directive when there is a significant change the residents physical, mental or psychosocial status. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on observation, interview, record review and review of facility policy the facility failed to ensure one resident's (Resident #51) catheter was evaluated timely due to urine leakage around the catheter insertion site. This affected one resident (Resident #51) out of three residents reviewed for catheters. The facility census was 73.<br><br>Findings included:<br><br>Review of Resident #51's medical record revealed an admitted [DATE] and diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms and obstructive and reflux uropathy.<br><br>Review of Resident #51's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 was cognitively intact, had total dependence of one staff member for toilet use and had an indwelling catheter.<br><br>Review of physician orders dated 07/08/22 revealed orders to change the foley catheter, size 16 French with a 10 cubic centimeter (CC) balloon, monthly and as needed for obstruction.<br><br>Review of Resident #51's care plan dated 07/15/22 included Resident #51 had an indwelling catheter, size 18 french with a 10 cubic centimeter (cc) balloon related to obstructive uropathy and urinary retention. Resident #51 would remain free from catheter-related trauma through the review date. Interventions included to position the catheter bag and tubing below the level of the bladder; monitor and document for pain or discomfort due to the catheter.<br><br>Review of Resident #51's physician orders dated 07/19/22 revealed foley catheter (indwelling) 16 french, 10 cc balloon to continuous drainage for urinary retention due to neurogenic bladder.<br><br>Observation on 08/01/22 at 12:00 P.M. of State tested Nursing Assistant (STNA) #539 providing catheter care for Resident #51 revealed Resident #51 stated his catheter leaked every day. Observation revealed Resident #51 had an indwelling catheter, and the disposable chux pad (waterproof bed pad) under Resident #51 was soaking wet with urine, and his gown was very wet on the bottom half with urine. Resident #51's buttock area was reddened with a nickel size abrasion on the bottom of left buttock. STNA #539 confirmed Resident #51 had reddened buttocks and an abrasion on the bottom of his left buttock. STNA #539 applied barrier cream and indicated the area looked better today than it had last time she cared for Resident #51. Resident #51 stated he told multiple nurses his catheter leaked, the nurses did not know why it leaked, and none of them did anything about the leaking catheter. Resident #51 stated he told all his nurses, he told today's nurse and yesterday's nurse and other nurses his catheter leaked.<br><br>Observation on 08/01/22 at 12:00 P.M. with Licensed Practical Nurse (LPN) #590 of Resident #51's leaking catheter, wet bed pad and gown indicated Resident #51 did not tell her about his leaking catheter. LPN #590 stated Resident #51 probably told the night nurse about his catheter. LPN #590 asked Resident #51 if his catheter was leaking and Resident #51 stated yes, it was leaking tons. LPN #590 stated she would look into his catheter problem.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 08/01/22 at 4:19 P.M. with STNA #524 revealed something was supposed to be done about Resident #51's catheter and the catheter leaked every day she worked. STNA #524 stated Resident #51 kept a towel over the catheter area because it leaked. STNA #524 stated when she provided care for Resident #51, the sheet under him and his gown were soaked with urine and needed to be changed. STNA #524 stated she told the nurses Resident #51's catheter leaked, and the nurses knew all about Resident #51's leaking catheter.<br><br>Interview on 08/01/22 at 4:40 P.M. with STNA #538 revealed Resident #51's gown and chux were wet sometimes when she provided care. STNA #538 stated she did not know why Resident #51's catheter was leaking and she told the nurse about it. STNA #538 indicated she did not remember which nurse she told.<br><br>Observation on 08/01/22 at 4:46 P.M. of STNA #538 providing care for Resident #51 revealed he had a towel covering the area where the catheter was. Further observation revealed the towel and chux were wet. STNA #538 confirmed the findings.<br><br>Interview on 08/01/22 at 4:48 P.M. with Assistant Director of Nursing/RN (ADON/RN) #805 revealed Resident #51 had chronic problems with his catheter. ADON/RN #805 stated when Resident #51's catheter was changed the issue was resolved. ADON/RN #805 indicated leaking was a chronic problem, the foley got displaced and the balloon needed adjusted or changed. ADON/RN #805 stated the nurses should change or fix the problem when they were told about it and there should be a progress note in Resident #51's medical record.<br><br>Interview on 08/01/22 at 4:52 P.M. with LPN #590 revealed she was told about Resident #51's leaking catheter earlier today but she had been too busy to go in to assess the problem. LPN #590 stated when she had a chance she would go in and fix the problem, or would pass it on to the night shift nurse.<br><br>Review of Resident #51's progress notes from 07/27/22 through 08/01/22 at 4:52 P.M. did not reveal documentation Resident #51's catheter was leaking or any intervention taken to correct the problem.<br><br>Review of the facility policy titled Foley Catheter Care, revised 10/2017, included the facility would promote urinary health and management to the resident with a foley catheter to provide the resident with dignity and to prevent the potential for urinary tract infection. Placement of the foley catheter would be checked every shift. The catheter would be replaced as needed, or in accordance with physician's orders. Indications for changing the catheter include obstruction, either by encrustation or mucous, symptomatic infection, or leakage around catheter. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>42011<br><br>Based on observation, interview, and review of the facility policy, the facility failed to ensure expired medications and expired medical supplies were removed from the medical supply rooms and the medication cart, after the expiration date. This had the potential to affect all 73 residents residing at the facility.<br><br>Findings include:<br><br>Interview on 07/27/22 at 8:03 A.M. with Assistant Director of Nursing/Registered Nurse (ADON/RN) #805 revealed the main medication room, of the five located in the facility, used by all nurses for all residents had an Alixa dispensing machine, intravenous (IV) supplies including IV solutions, IV starter kits, IV tubing, over the counter stock medications, and additional medical supplies.<br><br>Observation on 07/27/22 at 8:05 A.M. with ADON/RN #805 of the main medication storage room revealed there were two carts next to the Alixa machine filled with IV bags of solution. The room also had multiple cabinets filled with supplies and over the counter medications. Observation revealed two expired IV administration sets (IV tubing). The first set had an expiration date of 09/19/20 and the second set had an expiration date of 02/19/21. In the same room was a container of insyte needles, (needle used to start an IV) in the container was insyte 24 gauge with an expiration date of 12/31/19 and three insyte 20 gauge with an expiration date of 06/30/20. In one cabinet, a partially used isopropyl rubbing alcohol bottle had an expiration date 07/2016, a container of bleach wipes had an expiration date of 2019 (unable to read the month), in addition seven IV kits were located in a different storage area with one expiration date of 09/30/19 and six had expiration dates of 01/07/20. In the cart next to the Alixa machine were multiple bags of IV solution. Two IV bags labeled cipro 400 milligrams (mg) read discard after 01/28/22. ADON/RN #805 verified all findings.<br><br>Observation on 07/27/22 at 8:20 A.M. with ADON/RN #805 of the East Medication Storage room revealed six individual influenza vaccine syringes, located in the medication storage refrigerator, with an expiration date of 06/30/22. ADON/RN #805 verified all findings.<br><br>Observation on 07/27/22 at 8:27 A.M. with ADON/RN #805 of the 200 hall medication cart revealed a partially used container of clorox wipes with an expiration date of 06/22 and a container of purell hand sanitizing wipes with an expiration date of 04/22. ADON/RN #805 verified all findings.<br><br>Interview on 08/03/22 at 8:15 A.M. with the DON revealed there was no specific policy for disposal of medical supplies. The DON verified expired medications and medical supplies should have been removed from the medication rooms and medication carts at the time of expiration. The DON revealed this was the pharmacy technician who would come to the facility two times a month and check the expiration dates of the medications and medical supplies to assure all expired medications and supplies were removed from the supply room and disposed of.<br><br>(continued on next page) |

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| | 365758 | A. Building<br>B. Wing | 08/05/2022 |

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| Parma Care Center | 5553 Broadview Rd<br>Parma, OH 44134 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of the facility policy titled, Medication Storage in the facility revised August 2014, revealed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secured closures are immediately removed from inventory, disposed of according to procedures for medication disposal. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013<br><br>Based on observation, interview and record review the facility failed to ensure pureed food was prepared to the appropriate, smooth consistency for residents requiring pureed diets. This affected three residents (Resident's #9, #19, and #30) who had a physician order for pureed diet texture. The facility census was 73.<br><br>Findings include:<br><br>1. Review of Resident #9's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's disease and dysphagia. Resident #9's physician orders on 02/10/21 revealed a diet order for a regular diet with pureed texture and thin liquids consistency.<br><br>Review of Resident #9's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 was unable to complete the cognitive assessment due to rarely or never understood. Resident #9 required total dependence of one staff member for eating.<br><br>2. Review of Resident #19's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's disease, esophageal obstruction, and dysphagia. Resident #19's physician orders on 12/18/18 revealed orders for a regular diet, pureed texture and nectar thick liquids consistency.<br><br>Review of Resident #19's Annual MDS 3.0 assessment dated [DATE] revealed Resident #19 was unable to complete cognitive assessment and Resident #19 required supervision for eating.<br><br>3. Review of Resident #30's medical record revealed an admitted [DATE] and diagnoses included dysphagia and dementia. Resident #30's physician orders dated 03/18/22 revealed orders for a regular diet, pureed texture and nectar thick liquids consistency.<br><br>Review of Resident #30's Quarterly MDS 3.0 assessment dated [DATE] revealed resident had severe cognitive impairment and required limited assistance of one staff member for eating.<br><br>An observation was conducted on 07/28/22 at 10:35 A.M. of [NAME] #513 preparing pureed food for the resident meal. [NAME] #513 placed approximately six pickle spears into the food processor and turned the food processor on. [NAME] #513 stopped and started the food processor three times then placed the pickle puree in a metal container. Upon taste test of the pickle puree by the surveyor it was revealed the pureed pickle did not have a smooth texture but instead had chunks of pickle skin in it. [NAME] #513 verified the finding and stated she would puree the pickles a fourth time to create a smooth consistency.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An observation was conducted on 07/28/22 at 12:03 P.M. with Dietary Manager (DM) #576 and [NAME] #513 who revealed the pureed pickles were not going to be served to the residents for the lunch meal due to the inability to puree the pickles to remove the chunks of skin. [NAME] #513 stated she ran the pickles two more times through the food processor but the chunks of pickle skin were still present. [NAME] #513 informed the surveyor the food processor was on it's last leg and the kitchen staff had to run it several times just to get it to work. [NAME] #513 explained if it ran too long it would just stop working. DM #576 stated the pickle puree was not going to be served to the residents and instead peas had been pureed to use as a substitute for the pureed pickles. The pureed peas were already in a metal, steam table pan to be used for meal service. The taste test by the surveyor of the pureed peas revealed the pea puree had pieces of intact pea skin in it and was not a smooth consistency of puree. DM #576 confirmed the presence of pea skins in the puree and stated the pea puree would not be served to the residents. DM #576 stated the peas were processed three times through the food processor but the skins were still present.<br><br>Review of the facility policy titled Texture and Consistency-Modified Diets, undated, included the food and nutrition department would be responsible for preparing and serving the diet texture and fluid consistency as ordered by the physician. Care would be taken to serve the foods and fluids as ordered on the consistency-altered diet or fluids. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>42013<br><br>Based on observation, interview, and record review the facility failed to ensure cold foods were stored and served at proper temperatures, and failed to ensure the high temperature dish machine was consistently hitting 180 degrees Fahrenheit to properly sanitize the dishes and cookware. This had the potential to affect all residents receiving meals from the kitchen except for one resident (#226) who did not eat by mouth. The census was 73.<br><br>Findings included:<br><br>1. Observation on 07/25/22 at 8:15 A.M. of the kitchen with Dietary Manager (DM) #576 revealed there was a power outage starting on 07/25/22 at 1:30 A.M. and the walk-in cooler and walk-in freezer in the kitchen were not hooked up to the emergency back-up generator leaving that equipment without power to maintain proper cold storage temperatures. DM #576 stated they were opening the cooler and freezer as little as possible to conserve the cool temperatures. DM #576 stated she had been trying to get back-up power to the kitchen for three years but had not been successful. Observation of the tray line revealed [NAME] #513 and Dietary Aides (DA)'s #545 and #592 placing eggs, hot cereal and yogurt into disposable styrofoam containers with disposable utensils to be served to the residents. DM #576 stated they were able to cook eggs and hot cereal because the flat top stove was supplied by natural gas and not electricity.<br><br>Observation of tray line food temperatures on 07/25/22 at 8:20 A.M. completed by DM #576 revealed the yogurt was 62 degrees Fahrenheit (F) and the yogurt was in a metal container with no ice under the container to keep it cold. DM #576 stated the yogurt should be under 35 F. DM #576 stated they were about half done serving breakfast and she was worried about the food temperatures in the cooler and freezer. DM #576 revealed she arrived at the facility around 8:10 A.M. and did not have a chance to get ice before starting to serve the breakfast tray line so the yogurt had been sitting at room temperature as it was being dished into the disposable styrofoam containers for meal service.<br><br>Review of the food temperature log on 07/25/22 at 8:20 A.M. with DM #576 revealed there were no temperatures logged for any of the foods being served for the breakfast meal.<br><br>Interview on 07/25/22 at 8:20 A.M. with [NAME] #815 revealed she took the temperature of the breakfast food before tray line, but did not document it on the food temperature log because she wanted to get started with breakfast. [NAME] #815 was unable to report the temperatures of the food.<br><br>Observation of the walk-in-coolers on 07/25/22 at 8:25 A.M. with DM #576 revealed there were no thermometers visible through the window of the cooler. DM #576 confirmed there were no thermometers visible inside the cooler and the temperature was unable to be determined. DM #576 stated there was a thermometer in the back of the cooler, but it could not be seen and she did not know the temperature of the food in the cooler because she was trying to limit the number of times the door was opened to the cooler.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 07/25/22 at 8:25 A.M. with [NAME] #513 revealed she noted the temperature of the cooler when she arrived at the facility but did not document it anywhere because she wanted to get started with breakfast. [NAME] #513 stated she arrived around 5:30 A.M. and the cooler temperature was 45 F, but the walk-in-freezer thermometer was hard to read and she did not check the temperature.<br><br>Interview on 07/25/22 at 9:41 A.M. with Maintenance Supervisor (MS) #555 revealed he received a text at 1:12 A.M. from Licensed Practical Nurse (LPN) #574 regarding the power outage and arrived at the facility between 6:00 A.M. and 6:30 A.M. MS #555 confirmed the kitchen was not on a back-up emergency generator and he did not know why.<br><br>Interview on 07/25/22 at 9:41 A.M. with DM #576 revealed she was notified at 5:38 A.M. by [NAME] #513 of the power outage. DM #576 stated dietary staff did not work night shift and she did not know about the power outage until [NAME] #513 notified her at 5:38 A.M. so there had been no temperature monitoring of the food inside the coolers or freezer throughout the night.<br><br>Observation on 07/25/22 at 9:42 A.M. of the walk-in-cooler with DM #576 and MS #555 revealed a thermometer hanging in the cooler revealed the temperature was 50 F. DM #576 brought a digital thermometer with her into the cooler, stating the thermometer had been calibrated that morning. DM #576 checked food temperatures and found lactose-free milk in a cup with a lid had a temperature of 48.7 F, nectar thick consistency juice had a temperature of 50 F, chocolate milk in a single serving carton had a temperature of 42.2 F, two open gallons of milk had temperatures of 45.2 F and 46.9 F, a metal container with chicken salad had a temperature of 46.4 F, turkey lunch meat had a temperature of 43.3 F, a raw egg was 45.2 F, a hard-boiled cooked egg had a temperature of 50.3 F, a pitcher of milk had a temperature of 48. 4 F. DM #576 stated she needed to go through the cooler and discard food.<br><br>Interview on 07/25/22 at 9:50 A.M. with LPN #574 revealed on 07/25/22 at around 1:00 A.M. to 1:30 A.M. she heard a loud boom, a short time later the power went out and after about 10 seconds the generator kicked on and some of the facility power was restored. LPN #574 stated she notified the Director of Nursing (DON), the Administrator, the on-call supervisor and the Maintenance Supervisor #555 of the power outage. LPN #574 stated she was busy making sure the residents were taken care of and extension cords were used for important resident equipment like air mattresses, oxygen, tube feedings, and so LPN #574 did not enter the kitchen all night. LPN #574 stated the other nurses working night shift did not enter the kitchen or check the cooler and freezer.<br><br>Observation on 07/25/22 at 3:12 P.M. of the walk-in-cooler with DA #589 revealed the chicken salad was still in the cooler and had not been discarded.<br><br>Review of the menu changes on 07/25/22 at 3:15 P.M. due to the power outage for the lunch meal revealed deli sandwiches, potato chips, pickles and watermelon were served to the residents.<br><br>Interview on 07/25/22 at 3:21 P.M. with DM #576 confirmed the chicken salad was still in the cooler and had not been discarded. DM #576 stated she was very busy and still needed to go through the cooler. DM #576 stated she used the turkey lunch meat for the lunch meal because it was in sealed, unopened packages and she thought it was alright to use even though the temperature was 43.3 F earlier. DM #576 stated she would not have had anything to serve for the lunch meal if she did not use the turkey.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the Food Temperature Log on 07/25/22 at 3:21 P.M. for the lunch meal with DM #576 revealed the deli-sandwiches temperature was 42 F. The food temperature log stated cold foods temperature should be served at 41 F or lower. DM #576 confirmed the sandwiches should have had a temperature of 41 F or lower at the point of service.<br><br>Interview on 07/25/22 at 3:32 P.M. with Registered Dietician (RD) #627 revealed she was notified regarding the power outage around 6:30 A.M. RD #627 stated temperatures in the walk-in-cooler and walk-in-freezer should be monitored because there was a four hour window after the power outage for safe food storage and the food should not be in the danger zone. RD #627 was not sure how often the food temperatures should be monitored. RD #627 stated a temperature of 62 F for yogurt was in the danger zone.<br><br>Interview on 07/25/22 at 3:43 P.M. with the Administrator revealed the power was back on in the facility at 10:30 A.M.<br><br>Interview on 07/25/22 at 4:17 P.M. with the Administrator revealed even though the chicken salad was not removed from the walk-in-cooler there was no chance it could be served to the residents and the kitchen staff were in the kitchen the entire time. The Administrator stated no residents had been sent out for food borne illness in the past month.<br><br>Interview on 07/25/22 at 3:45 P.M. with DM #576 revealed the food temperatures were checked at 8:15 A.M., 9:41 A.M. and 2:00 P.M. DM #576 stated she did not have the food temperatures documented on a disaster log because she had been so busy today.<br><br>Review of the facility policy titled Food Safety and Sanitation, undated, included stored food was handled to prevent contamination and growth of pathogenic organisms. Refrigerated foods were stored at or below 41 degrees Fahrenheit.<br><br>Review of the facility policy titled Food Safety Requirements, undated, included holding temperature (ready for service) should be 135 F or above for hot foods and 41 F or below for cold foods.<br><br>2. Observation on 07/25/22 at 10:40 A.M. with Dietary Aide (DA) #545 and Dietary Manager (DM) #576 of the dish machine wash and rinse cycle revealed the wash cycle gauge was not functioning and did not display the wash cycle water temperature. DA #545 confirmed the wash cycle gauge was broken and had been broken for awhile. DM #576 confirmed the gauge was broken and the representative from the service company was called about it two weeks ago.<br><br>Record review on 07/25/22 at 10:40 A.M. with DM #576 of the Dish Machine Temperature Log revealed on 07/16/22 and 07/17/22 temperatures for the wash and final rinse cycles were not documented for the breakfast and lunch meals, 07/22/22 did not have temperatures for the wash and final rinse cycles documented for the breakfast, lunch and dinner meal, on 07/23/22 there were no temperatures documented for the breakfast and lunch meals, on 07/24/22 there were no temperatures documented for the breakfast, lunch, and dinner meals, and on 07/25/22 there were no temperatures documented for the breakfast meal. DM #576 confirmed the temperatures were not documented.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 07/28/22 at 10:45 A.M. with DA #545 and DM #576 of the dishwashing machine completing washing and rinse cycles revealed the rinse temperature did not reach 180 degrees F. Observation of the dishwashing machine complete five cycles revealed the rinse temperature only reached 176 F. DM #576 stated sometimes the dishwashing machine lost heat as the day progressed and the representative from the dishwashing machine company was called about the issue. DM #576 stated when the temperature did not reach 180 F the dishes were washed two to three times. DM #576 stated the dishwashing temperature was double checked with a paper thermometer as a back-up to ensure dishes were sanitized appropriately. DM #576 revealed the paper thermometers were accurate to 160 F so were not able to measure up to the required 180 F for the final rinse.<br><br>Review of the Service Detail Report dated 07/28/22 at 2:04 P.M. from the dishwasher company included documentation the dishwasher was not hitting the rinse temperature and the thermostat was turned up a bit to hit 184 F after a few tests.<br><br>Review of the manufacturer information for the paper thermometers titled Paper Thermometer revealed the paper thermometer was a temperature sensitive tape device that read up to 160 degrees F.<br><br>Review of the facility policy titled Dish Machine Temperature Log, undated, included staff would record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition services would spot check the log to assure temperatures were appropriate and staff was correctly monitoring dish machine temperatures.<br><br>Review of the facility policy titled Dishwashing, undated, included dishes, pots and pans would be washed using procedures, chemicals and equipment that resulted in clean, sanitized dishes, pans flatware and utensils. Dish machine temperatures were logged at each meal on the Dish Machine Temperature Log and minimum temperatures, as required by the manufacturer were wash 150 to 160 F and Final Rinse 180 to 195. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>39968<br><br>Based on record review and interview with the Administrator, the facility failed to provide a Facility Assessment identifying what resources would be needed to provide competent care to the residents during both day-to-day operations and emergencies. This had the potential to affect all 73 residents residing in the facility. The facility census was 73.<br><br>Findings included:<br><br>Interview on 07/25/22 at 9:12 A.M., during the entrance conference, the Administrator was asked to make the Facility Assessment available to the survey team.<br><br>Record review was conducted of the facility document titled IFC Self-Assessment Guide for Health Care Organization, dated 01/09/22. and provided by the Administrator to the survey team as the Facility Assessment requested at the entrance conference. The document consisted of 13 pages of self-assessment elements for the facility. The document was completed by the Administrator and the Director of Nursing as indicated on the first page. There were no members of the governing body or other facility staff listed as participants in this assessment. It did not contain both the number of residents and the facility capacity, the care required by the resident population to meet the acuity needs of the residents, the staff competencies necessary to provide the level and types of care needed for the resident population, the physical environment, equipment, services and other physical plant considerations needed to care for the residents, any ethnic, cultural or religious factors for the residents nor did it contain information on the facility resources ( all physical structures, medical and non-medical equipment), medical services, staffing plans including management and non-management positions, information on technology resources and resources needed in case of an emergency. On page three there was a typed line reading see detailed facility assessment.<br><br>An interview was conducted on 07/28/22 at 3:40 P.M., 08/01/22 at 4:56 P.M. and 08/02/22 at 2:50 P.M. with the Administrator regarding the contents of the ICF Self-Assessment Guide for Health Care Organizations, dated 01/09/22, compared to the federal regulation requirements for content of the Facility Assessment. The Administrator verified the document was provided by him as the current Facility Assessment requested by the survey team and he had provided said document to two of the three surveyors on the survey team. The Administrator provided no additional information to reflect a detailed Facility Assessment had been completed for the facility. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observations, interviews, and record review, the facility failed to implement appropriate infection control practices regarding the proper use of personal protective equipment (PPE) by all direct care staff providing care and services to residents on transmission based precautions for COVID-19 and COVID-19 quarantine precautions. This had the potential to affect all 73 residents residing in the facility. The facility also failed to ensure reusable medical equipment (glucometer) was appropriately sanitized in between residents affecting Resident #29, #51 and #324. The facility census was 73.<br><br>Findings included:<br><br>1. Record review revealed Resident #48 had an admitted [DATE]. Diagnoses included Alzheimer's disease. An additional diagnosis of COVID-19 was added on 07/18/22. Resident #48 resided in the memory care unit.<br><br>Record review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #48 had severe cognitive impairment. Resident #48 required limited assistance and supervision with activities of daily living.<br><br>Record review of the care plan dated 07/18/22 revealed Resident #48 was on droplet isolation precautions due to positive COVID-19. Interventions included to adhere to infection control precautions at all times by all staff, and wear appropriate personal protective equipment per policy.<br><br>Record review of the physician order dated 07/18/22 revealed an order for droplet precautions due to a diagnosis of COVID 19.<br><br>Observation on 07/25/22 at 9:26 A.M. revealed Wound Care Consultant Certified Nurse Practitioner (CNP) #906 entered Resident #48's room without putting on an isolation gown. Resident #48 was lying in bed and began sitting up. Wound Care Consultant CNP #906 went over to Resident #48 and began assisting Resident #48. Wound Care Consultant CNP #906 then closed Resident #48's door for privacy. Resident #48 had a sign on the door to please see the nurse before entering and an isolation cart next to the entrance of the door. Wound Care Nurse Registered Nurse (RN) #803 was at the treatment cart next to Resident #48's doorway and verified Resident #48 was diagnosed with COVID-19 requiring isolation. Wound Care Nurse RN #803 opened Resident #48's door and instructed Wound Care Consultant CNP #906 Resident #48 was diagnosed with COVID -19 and she would need to leave his room to put on the appropriate PPE.<br><br>Interview on 07/25/22 at 9:30 A.M. with Wound Care Consultant CNP #906 revealed she was unaware Resident #48 was on isolation and was not notified by the facility it was in COVID-19 outbreak status. Wound Care Consultant CNP #906 revealed she did not read the sign posted on Resident #48's door and needed to be directed by staff before entering a room if the resident was on isolation. Wound Care Consultant CNP #906 confirmed she did not wear an isolation gown prior to assisting Resident #48 with care. Wound Care Consultant CNP #906 then left the unit without washing her hands, changing her mask or cleaning her goggles.<br><br>(continued on next page) |

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| | 365758 | A. Building<br>B. Wing | 08/05/2022 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 07/25/22 at 9:33 A.M. with Wound Care Nurse RN #803 confirmed Wound Care Consultant CNP #906 was in Resident #48's room with the door closed assisting Resident #48 to prepare for wound care. Wound Care Nurse RN #803 confirmed Wound Care Consultant CNP #906 did not have the appropriate PPE on, did not clean her goggles, change her mask, or wash her hands prior to exiting the unit onto another residential area.<br><br>Observation on 07/25/22 at 9:39 A.M. revealed Hospice STNA #907 entering the memory care unit where three Residents (Resident #48, #27, and #53) were positive for COVID-19. Hospice STNA #907 verified she was not wearing goggles nor a face shield for eye protection.<br><br>Interview on 07/25/22 at 9:40 A.M. with LPN #521 confirmed Hospice STNA #907 was not wearing goggles nor a face shield when she entered the unit. LPN #521 revealed Hospice STNA #907 was there to assist Hospice Resident #21 who also resided in the memory care unit and staff should be wearing eye protection on the unit.<br><br>Interview on 07/25/22 at 9:53 A.M. with the DON revealed contract staff such as Hospice staff would be expected to wear appropriate PPE when entering the facility and entering a residents room requiring isolation precautions. The DON revealed she did not know how the contract staff were notified of the facility outbreak status.<br><br>Observation on 07/25/22 at 3:02 P.M. revealed STNA #550 entered the memory care unit and was not wearing goggles nor a face shield. STNA #550 verified she was not wearing goggles or a face shield when she entered the unit.<br><br>Observation on 07/27/22 at 1:13 P.M. revealed RN #602 entered Resident #48's room with the bottom strap of the N-95 mask dangling under his chin. After exiting Resident #48's room, RN #602 did not clean his goggles and placed the new N-95 mask on with the bottom strap dangling under his chin.<br><br>Interview on 07/27/22 at 1:18 P.M. with RN #602 confirmed he entered Resident #48's room with the bottom strap of the N-95 mask dangling under his chin. After exiting Resident #48's room, RN #602 verified he did not clean his goggles and placed the new N-95 mask on with the bottom strap dangling under his chin.<br><br>2. Record review for Resident #27 revealed an admitted [DATE]. Diagnosis included dementia and muscle weakness. An additional diagnosis of COVID-19 was dated 07/18/22.<br><br>Record review of the Admission MDS 3.0 assessment dated [DATE] revealed Resident #27 had moderately impaired cognition. Resident #27 required extensive assistance for bed mobility, transfers, dressing, grooming, and toilet use.<br><br>Record review of the care plan dated 07/18/22 revealed Resident #27 was on droplet precautions due to a diagnosis of COVID-19. Interventions included to adhere to infection control precautions at all times by all staff.<br><br>Record review of the physician order for Resident #27 dated 07/19/22 revealed an order for droplet isolation due to a diagnosis of COVID-19.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 07/25/22 at 12:33 P.M. revealed State tested Nursing Assistant (STNA) #504 was assisting Resident #27 in her room with setting up the lunch tray sitting in front of Resident #27. STNA #504's isolation gown was not tied at the top or at the waist. The top of the isolation gown was dangling at STNA's elbows as she was setting up the lunch tray. STNA #504 continued assisting Resident # 27 with positioning and the lunch tray.<br><br>Interview on 07/25/22 at 12:37 P.M. with STNA #504 confirmed the isolation gown was not tied and was dangling at the elbows while providing care for Resident #27. STNA #504 confirmed she did not change her mask, clean her goggles or wash her hands prior to leaving Resident #504's room.<br><br>Observation on 07/25/27 at 12:38 P.M. revealed STNA #504 then walked up the hall, retrieved a lunch tray for Resident #18 (not on isolation precautions), she did not change her mask, clean her goggles or wash her hands and delivered the lunch tray to Resident #18.<br><br>Interview on 07/25/27 at 12:41 P.M. with STNA #504 verified she delivered the lunch tray to Resident #18 and did not wash her hands, clean goggles or change her mask after assisting Resident #27 and before assisting Resident #18.<br><br>Observation on 07/27/22 at 4:09 P.M. revealed Radiology Technician #908 was in Resident #27's room performing a procedure. Radiology Technician #908 was wearing his N-95 mask below his mouth exposing his mouth and nose and was not wearing goggles.<br><br>Interview on 07/27/22 at 4:17 P.M. with Radiology Technician #908 verified his face mask was below his mouth while in Resident #27's room and he had no goggles on. Radiology Technician #908 left the unit and did not change his mask.<br><br>3. Record review for Resident #326 revealed an admitted [DATE]. Resident #326 was discharged to the hospital on 07/14/22 and returned 07/19/22. Diagnosis included acute and subacute infective endocarditis and sepsis.<br><br>Record review of the MDS dated [DATE] revealed Resident #326 had intact cognition. Resident #326 required limited assistance of one for bed mobility, extensive assistance of one for transfers and limited assistance of one for toilet use and personal hygiene.<br><br>Record review of the care plan dated 07/25/22 for Resident #326 revealed resident was on droplet isolation precautions related to guidelines for quarantine related to recent hospitalization . Interventions included to adhere to standard infection control precautions at all times by all staff.<br><br>Record review of the physician order for Resident #326 dated 07/19/22 revealed quarantine for 14 days post admission as COVID precautions.<br><br>Observation on 07/26/22 at 11:47 A.M. of RN #544 assisting Resident #326 with medication administration revealed RN #544 donned her isolation gown and did not tie the top of the gown. RN #326 did not place a surgical mask over the N-95 mask. The top of the gown fell to RN #544's elbows while providing care to Resident #326. RN #544 exited Resident #544's room then did not change the N-95 mask or clean her goggles.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 07/26/22 at 11:57 A.M. with RN #544 while she was walking up the hall confirmed she did not tie the top of the gown causing it to fall to the top of her elbows while providing care to Resident #326. RN #544 also verified she did not change her mask prior to exiting the room and she did not clean her goggles.<br><br>Interview on 08/01/22 at 9:31 A.M. with Infection Preventionist Assistant Director of Nursing RN #805 revealed all staff including contract staff were expected to donn and doff appropriate PPE prior to entering rooms positive for COVID-19 or on quarantine including an N-95 mask and goggles or face shield while in the residential areas of the facility.<br><br>4. Record review for Resident #29 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus (dm).<br><br>Record review of the physician orders for Resident #29 revealed an order for novolog flex pen ( an insulin pen) dated 07/06/22. The order was to inject as per sliding scale after checking the resident's blood sugar level.<br><br>Observation on 07/26/22 at 8:20 A.M. with RN #544 who was assessing Resident #29's blood sugar level using a glucometer. After RN #544 assessed Resident #29's blood sugar, RN #544 then wiped the glucometer off with a hand sanitizer wipe for less than five seconds and sat the glucometer directly on top the medication cart.<br><br>Interview on 07/26/22 at 8:24 A.M. with RN #544 confirmed she briefly wiped the glucometer off with a hand sanitizer wipe and revealed she would normally use a bleach wipe for 30 seconds but she did not have bleach wipes. RN #544 verified she used the same glucometer for all of her residents who required a blood sugar assessment.<br><br>5. Record review for Resident #324 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus.<br><br>Record review of the physician orders for Resident #324 revealed an order for the insulin lispro dated 07/14/22. The order was to inject as per sliding scale after checking the residents blood sugar level.<br><br>Observation on 07/26/22 at 08:35 A.M. with RN #544 who was assessing Resident #324's blood sugar using a glucometer. After using the glucometer, RN #544 wiped the glucometer off with a bleach wipe for less than six seconds, then assessed Resident #29's blood sugar. RN #544 then wiped the glucometer off again with a bleach wipe for approximately six seconds after assessing the blood sugar for Resident #29 then sat the glucometer on top the medication cart which RN #544 verified at the time of the finding.<br><br>6. Record review for Resident #51 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus.<br><br>Record review of the physician orders for Resident #51 revealed an order for humalog (insulin)solution dated 07/19/22 inject as per sliding scale after assessing the blood sugar.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 07/26/22 at 8:44 A.M. of RN #544 assessing Resident #51's blood sugar using a glucometer revealed after RN #544 assessed Resident #51's blood sugar, she placed the glucometer in the top drawer of the medication cart without cleaning the glucometer.<br><br>Interview on 07/26/22 at 8:56 A.M. with RN #544 confirmed she did not clean the glucometer after assessing Resident #51's blood sugar, and she placed the glucometer in the top drawer of the medication cart. RN #544 confirmed she used the same glucometer for Resident #29, #324, and #51.<br><br>Interview on 07/26/22 at 9:10 A.M. with the DON revealed the medication cart should have had three glucometers on it and each glucometer should have been cleaned a minimum of two minutes before the next use because that is what was indicated in the manufacturer instructions so that is what the nurse should follow to clean the glucometer. The DON provided the manufactures instructions titled, Cleaning and disinfecting the On Call Pro Blood Glucose Monitoring System.<br><br>Record review of the facility policy titled, Cleaning and Disinfecting of Equipment, dated October 2017, included the manufacturers guidance titled, Cleaning and disinfecting the On Call Pro Blood Glucose Monitoring System. The instructions included a cautionary statement to not disinfect the meter with any product containing bleach. The meter should be disinfected using Super Sani cloth germicidal disposable wipes with a contact time of two minutes.<br><br>Record review of the Community Risk Level for Cuyahoga County for COVID-19, updated 07/28/22, revealed the community risk level was high.<br><br>Record review of the policy titled, Covid-19, Coronovirus, revised 06/28/22, revealed after receipt of confirmed COVID 19 test results the resident would remain in droplet precautions per guidelines. Any new admissions would be placed in a 14 day quarantine if not updated. The facility would provide cumulative updates to their residents, their representatives, families and staff at least weekly during an outbreak or by 5:00 P.M. the next calender day following the subsequent occurrence of either: each time a COVID 19 infection was identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.<br><br>Record review of the facility policy titled, Covid 19 Donning and Doffing, revised 01/05/22, revealed if the facility was in outbreak status for COVID-19 eye protection must be donned by all staff in all zones. Instructions included, while donning the gown, fully cover the torso from neck to knees, arms to end of wrist, and wrap around the back, fasten in back of neck and waist. The donning of the mask instructions indicated staff should secure ties or plastic bands at the middle of head and neck. For residents on a 14 day quarantine, a surgical mask would be worn over the N-95 mask and disposed of after exiting quarantined rooms and before entering another residents room. Wash hands or use alcohol based hand sanitizer immediately after removing all PPE. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>42013<br><br>Based on observation, interview and record review the facility failed to ensure the high temperature dish machine was in good repair and functioning properly, and failed to ensure the kitchen's food processor used to make pureed foods was in good repair. This had the potential to affect all residents residing in the facility except for one resident (#226) who did not eat by mouth. The facility census was 73.<br><br>Findings include:<br><br>1. Observation on 07/25/22 at 10:40 A.M. with Dietary Aide (DA) #545 and Dietary Manager (DM) #576 of the dish machine wash and rinse cycle revealed the wash cycle gauge was not functioning and did not display the wash cycle water temperature. DA #545 confirmed the wash cycle gauge was broken and had been broken for awhile. DM #576 confirmed the gauge was broken and the representative from the company was called about it two weeks ago.<br><br>Review of the facility document titled Extra Service Request, dated 07/25/22 and timed 12:07 P.M., from the dish machine company representative included temperature gauges were bad and both the rinse and wash temperature gauges were replaced.<br><br>Observation on 07/28/22 at 10:45 A.M. with DA #545 and DM #576 of the dish machine completing washing and rinse cycles revealed the rinse temperature did not reach 180 degrees Fahrenheit (F). Observation of the dish machine complete five cycles revealed the rinse temperature only reached 176 F. DM #576 stated sometimes the dish machine lost heat as the day progressed and the representative from the dish machine company was called about the issue. DM #576 stated when the temperature did not reach 180 F the dishes were washed two to three times. DM #576 stated the dishwashing temperature was double checked with thermolabels ( paper thermometers) as a back-up to ensure dishes were sanitized appropriately. DM #576 confirmed the thermolabels were accurate to 160 F (not the required 180 F).<br><br>Review of the document Service Detail Report, dated 07/28/22 at 2:04 P.M., from the dish machine company included the dishwasher was not hitting the rinse temperature and the thermostat was turned up a bit to hit 184 F after a few tests.<br><br>Review of the Extra Service Request,, dated 07/29/22 at 1:16 P.M., from the dish machine company representative included the dishwasher was not hitting the rinse temperature so burnt wires and the thermostat were replaced.<br><br>2. An observation was conducted on 07/28/22 at 10:35 A.M. of [NAME] #513 preparing pureed food for the resident meal. [NAME] #513 placed approximately six pickle spears into the food processor and turned the food processor on. [NAME] #513 stopped and started the food processor three times then placed the pickle puree in a metal container. Upon taste test of the pickle puree by the surveyor it was revealed the pureed pickle did not have a smooth texture but instead had chunks of pickle skin in it. [NAME] #513 verified the finding and stated she would puree the pickles a fourth time to create a smooth consistency.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | An observation was conducted on 07/28/22 at 12:03 P.M. with Dietary Manager (DM) #576 and [NAME] #513 who revealed the pureed pickles were not going to be served to the residents for the lunch meal due to the inability to puree the pickles to remove the chunks of skin. [NAME] #513 stated she ran the pickles two more times through the food processor but the chunks of pickle skin were still present. [NAME] #513 informed the surveyor the food processor was on it's last leg and the kitchen staff had to run it several times just to get it to work. [NAME] #513 explained if it ran too long it would just stop working. DM #576 stated peas had been pureed to use as a substitute for the pureed pickles. The pureed peas were already in a metal, steam table pan to be used for meal service. The taste test by the surveyor of the pureed peas revealed the pea puree had pieces of intact pea skin in it and was not a smooth consistency of puree. DM #576 confirmed the presence of pea skins in the puree and stated the pea puree would not be served to the residents. DM #576 stated the peas were processed three times through the food processor but the skins were still present. |